ARKANSAS DEPARTMENT OF WORKFORCE EDUCATION
DIVISION OF REHABILITATION SERVICES

Arkansas Governor's Commission on People with Disabilities
Scholarship Application Instructions

OFFICIAL APPLICATION

The Arkansas Governor's Commission on People with Disabilities will award several student scholarships. Applications are graded by the Scholarship Committee on the basis of financial need, academic achievement, school and community involvement, goals and the specific challenges faced due to your disability. Applicants are recommended to the full Commission for approval. The scholarship recipients will be recognized at a reception in Little Rock in June 2015. The scholarship will be sent directly to the academic institution.

Please follow the directions given below.

PLEASE PRINT OR TYPE YOUR APPLICATION. ALL blanks must be completed. If you have difficulty providing this information in typed or printed form, you may submit an application on audiocassette. If additional space is required, please use a separate sheet of paper. Please write your name, social security number and the section heading, with the continuation of your response.

EACH ITEM BELOW MUST BE INCLUDED OR YOUR APPLICATION WILL NOT BE CONSIDERED!

☐ Completed and signed Governor's Commission on People with Disabilities Application.

☐ Completed and signed Governor's Commission on People with Disabilities certification of disability. This form must be signed by a professional health care provider.

☐ A letter from an official of your school/university confirming that you have been accepted or are currently enrolled in a college/university and in good standing.

☐ Three (3) letters of recommendation from an adult (not a relative) who can testify to your financial need, academic abilities, character, volunteer services and community involvement.

☐ Official transcript from high school and/or college.

☐ A brief (4-5 paragraph) biography

My check in each of the above boxes indicates that I have provided all necessary information to be considered for an Arkansas Governor's Commission on People with Disabilities Scholarship.

Signature (if over 18) _____ Date _____

Parent/Guardian _____Date _____

All requested documents MUST be attached with this application;
If not, your application will not be considered.

No application forms from previous years will be accepted.
APPLICATIONS MUST BE POSTMARKED BY FEBRUARY 28, 2015
Send completed applications and attachments to:

Arkansas Governor's Commission on People with Disabilities
Scholarship Committee
601 West Capitol Avenue, Little Rock, AR 72201

Arkansas Governor's Commission on People with Disabilities Scholarship Application

Name (Mr.) (Miss) (Mrs.) _____

Date of Birth _____Male_____Female_____ ___ Age _____

Address _____ City _____

State_____ Zip_____ Telephone _____ E-mail _____

Name of school last attended _____

Month/Day/Year of graduation _____ or GED _____

Name of college you currently attend_____plan to attend_____

Accepted _____Part time _____ Full time _____(12 hours minimum)

Expected tuition for chosen school _____ per year

SAT score _____ ACT score _____ GPA_____

Financial Need: (10 points) Please indicate your family income* from the following categories:

a) $0-15,000; b) $15,000-25,000; c) $25,000-40,000; d) $40,000-65,000; e) greater than $ 80.000

Number of children in the home _____ Total family members _____

Do you have dependents? If yes, how many? _____

Do you receive SSD or SSDI? ____Yes _____No Social Security Number_____

Have you previously received a scholarship from the Governor's Commission? ___Yes ___No

Have you received or will you receive any other scholarships or grants, such as Pell? If so, please list.

	Source	School Year (s)	Amount
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

What is your disability? Indicate how long (20 points)

_____

_____

List Recent (2-3 years) **school, community and work** involvement. (10 points)

	Date(s)	Organization	Activity or Position	Hrs/ week
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

*Family income includes earnings or other sources of income by the student and parents. If the student is 21 years or older and living independently, the student's income is applicable.

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Continue **school, community and work** activities.

	Date(s)	Organization	Activity or Position	Hrs/week
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

Briefly describe your career goals (15 points)

_____

_____

_____

What effects (both positive and negative) has your disability had on your life thus far? What effects do you think it will have on your future? (20 points) Use additional pages if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

Do you plan to live on campus or commute? _____

If you have any additional information you would like to share, please provide on an attached page.

Please include three (3) letters of recommendation, including academic references (10 points)

If under 21, please list parent's names

_____

I hereby attest that all information submitted in this application is true and correct to the best of my knowledge.

Applicant Name_____ Date _____

Parent's signature if under 21 _____

Arkansas Department of Workforce Education
Division of Rehabilitation Services
Arkansas Governor's Commission on People with Disabilities
26 Corporate Hill Drive
Little Rock, AR 72205
Telephone: (501) 296-1637 V/TCDD
Fax: (501) 296-1883

Scholarship Application Part II, Certification of Disability

This form is to be completed & signed by a Health Care Provider (Please Type/ Print Legibly)

Please Check One:
☒ Physician ☐ Licensed Health Care Professional ☐ Rehabilitation Counselor ☐ Other

Applicant's Name _____ Date of Birth _____

Address _____

City _____ State_____ Zip Code _____

County _____

Medical diagnosis of condition causing applicant's disability

_____

_____

_____

Is this a permanent condition? ____Yes _____ No If no, expected duration ____/_____/____

Life Activity Affected	**Severity/Significance**	**Assistive Aids**
Vision	_____	_____
Hearing	_____	_____
Communication	_____	_____
Mobility	_____	_____
Other (_____)	_____	_____

Information contained within this application is considered personal and may be protected by both State and Federal laws and regulation. This information is to be treated with the highest degree of confidentiality and may only be exchanged **if** necessary.

I am knowledgeable of the applicant's medical condition(s) and based on my professional opinion, I certify that the above information is true and correct.

Name of the Care Provider _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____

Signature _____ Date _____